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UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF SAFETY AND ENVIRONMENTAL ENFORCEMENT
GULF OF AMERICA REGION

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **30-MAR-2026** TIME: **0935** HOURS
2. OPERATOR: **Nugulf Operating, L.L.C.**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **Elevating Lift Boats**
   REPRESENTATIVE:
   TELEPHONE:

- [ ] STRUCTURAL DAMAGE
- [X] CRANE
- [ ] OTHER LIFTING
- [ ] DAMAGED/DISABLED SAFETY SYS.
- [ ] INCIDENT >$25K
- [ ] H2S/15MIN./20PPM
- [ ] REQUIRED MUSTER
- [ ] SHUTDOWN FROM GAS RELEASE
- [ ] OTHER

3. OPERATOR/CONTRACTOR REPRESENTATIVE/SUPERVISOR ON SITE AT TIME OF INCIDENT:

4. LEASE: **00693**
   AREA: **SP** LATITUDE:
   BLOCK: **27** LONGITUDE:

5. PLATFORM: **5**
   RIG NAME: *** LIFT BOAT**

6. ACTIVITY:
   - [ ] EXPLORATION(POE)
   - [ ] DEVELOPMENT/PRODUCTION(DOCD/POD)
   - [X] DECOMMISSIONING

7. TYPE:
   INJURIES:
   - [ ] HISTORIC INJURY

	OPERATOR	CONTRACTOR
[ ] REQUIRED EVACUATION		
[ ] LTA (1-3 days)		
[ ] LTA (>3 days)		
[ ] RW/JT (1-3 days)		
[ ] RW/JT (>3 days)		
[ ] FATALITY		
[ ] Other Injury		

   - [ ] POLLUTION
   - [ ] FIRE
   - [ ] EXPLOSION

   LWC
   - [ ] HISTORIC BLOWOUT
   - [ ] UNDERGROUND
   - [ ] SURFACE
   - [ ] DEVERTER
   - [ ] SURFACE EQUIPMENT FAILURE OR PROCEDURES

   COLLISION [ ] HISTORIC [ ] >$25K [ ] <=$25K

8. OPERATION:
   - [ ] PRODUCTION
   - [ ] DRILLING
   - [ ] WORKOVER
   - [ ] COMPLETION
   - [ ] HELICOPTER
   - [ ] MOTOR VESSEL
   - [ ] PIPELINE SEGMENT NO.
   - [ ] OTHER
   - [ ] TEMP ABAND
   - [ ] PERM ABAND
   - [ ] DECOM PIPELINE
   - [ ] DECOM FACILITY
   - [X] SITE CLEARANCE

9. CAUSE:
   - [X] EQUIPMENT FAILURE
   - [X] HUMAN ERROR
   - [ ] EXTERNAL DAMAGE
   - [ ] SLIP/TRIP/FALL
   - [ ] WEATHER RELATED
   - [ ] LEAK
   - [ ] UPSET H2O TREATING
   - [ ] OVERBOARD DRILLING FLUID
   - [ ] OTHER _____

10. WATER DEPTH: **60** FT.
11. DISTANCE FROM SHORE: **4** MI.
12. WIND DIRECTION:
    SPEED: M.P.H.
13. CURRENT DIRECTION:
    SPEED: M.P.H.
14. SEA STATE: FT.
15. PICTURES TAKEN:
16. STATEMENT TAKEN:

INCIDENT SUMMARY:

On 30 March 2026, at approximately 0935 hours, a crane incident occurred aboard the EBI Services (EBI) Lift Boat (L/B) while conducting decommissioning and diving operations at the South Pass (SP) 27 #5 platform, operated by Nugulf Operating L.L.C.(Nugulf). During lifting operations, the crane's anti–two block (A2B) weight became detached from its anchor point at the boom tip. After separating, the A2B weight slid down the fast line cable and impacted the fast line ball's wedge socket. This impact caused the fast line wire rope to fail at its entry point into the wedge socket, resulting in the fast line ball and the detached weight falling roughly 12 feet onto the vessel deck. A diver working in proximity observed the falling components and attempted to move away from the falling weight. However, as the diver turned, the recoiling wire rope struck him on the right torso. An immediate all stop was initiated, and the area was secured. The diver sustained minor injuries but did not require or seek medical attention. No serious injuries or environmental pollution occurred because of the incident.

SEQUENCE OF EVENTS:

On 30 March 2026, a Gulf Stream Diving and Salvage employee (the Diver) was preparing to conduct diving operations and was in the process of attaching the crane's fast line ball to the basket used for diver deployment. After the basket was secured to the crane's fast line, the EBI Crane Operator attempted to lift the assembly. During this operation, the crane boom contacted and activated the high angle limit switch as designed. When the boom reached this limit, the Crane Operator attempted to boom down; however, the crane experienced abrupt, repeated jerking motions while the Operator continued to attempt functional inputs against the engaged limit.

During these abnormal boom movements, the A2B weight became detached from the boom tip. Once separated, the weight traveled down the fast line wire rope and impacted the fast line ball's wedge socket. The impact at the wedge socket caused the fast line wire rope to shear at the socket connection. Following line failure, the fast line ball and A2B weight fell to the deck of the lift boat.

The nearby Diver observed the A2B weight detach and attempted to remove himself from the hazard zone. However, when the wire rope parted, it recoiled and made glancing contact with the Diver's right side/hip. The Diver sustained minor bruising and superficial abrasions. According to Nugulf Operating's Report of Incident, the Diver immediately returned to duty and no first-aid treatment was required.

Once it was confirmed that the Diver had no significant injuries, Stop Work Authority (SWA) was initiated. On 30 March 2026, EBI dispatched crane mechanics/inspectors to the L/B to conduct a condition assessment and perform required repairs. Between 31 March and 02 April 2026, corrective repairs were completed. All damaged components were retained for further evaluation. On 16 April 2026, the Bureau of Safety and Environmental Enforcement (BSEE) received EBI's complete investigation report detailing the mechanical failure, contributing factors, and corrective actions.

BSEE INVESTIGATIONS:

On 30 March 2026, Nugulf submitted an electronic incident report to BSEE describing a crane related failure on a L/B, along with supporting documentation. On 31 March 2026, BSEE assigned an Accident Investigator (AI) to the case, who subsequently contacted Nugulf for additional information. The AI conducted an on site investigation on 14

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April 2026. During the on-site investigation, photographs were taken, the incident location was inspected, additional documentation was requested, and the damaged crane components that had been removed after the incident were examined.

During the on-site investigation and review of witness statements and documentation, several material issues were identified. Examination of the fast line wire rope revealed localized corrosion where the wire rope would have entered the wedge socket and where the wire rope had sheared. In addition, the A2B weight's wire rope displayed distinct wear patterns consistent with repeated abrasion against an external surface, resulting in the cut like damage observed.

Further evidence indicates that the underlying cause of this wear was a bent pulley located at the boom tip. The pulley's mounting bolt had become deformed, allowing the A2B cable to travel off track and make unintended contact with adjacent surfaces. It was also noted that the A2B weight involved in the incident had been reinstalled prior to the AI's site visit. During that reinstallation, slight modifications were made, including the addition of a supplemental wire rope lanyard secured to the boom tip. This secondary retention was intended to prevent a recurrence of uncontrolled weight drop and enhance overall system safety.

Further inspection of the boom tip assemblies found that the pulleys and associated mounting hardware appeared to have been recently replaced. Both the main block A2B weight support cable and the fast line A2B weight support cable also appeared to be new. The fast line wedge socket and associated fittings showed no visible signs of wear or degradation, suggesting recent replacement. Additionally, the fast line hoist line itself appeared newly installed, as no corrosion or deterioration was present on the wire rope.

The wire rope that failed upon contact had been inspected prior to the incident; however, the required annual "cut and slip" procedure was not performed by the Crane Inspector during the annual crane inspection in April 2025 according to service reports, inspection records and EBI's investigation report. EBI policy mandates that, during the annual crane inspection, the load bearing segment seated in the wedge socket be removed and a new termination established with previously unused cable. This process is critical because wire rope segments confined within wedge sockets are subjected to localized compression, moisture intrusion, and reduced lubrication pathways. When not periodically cut and slipped, these confined segments can develop internal corrosion, degradation of wire strands, and a measurable reduction in tensile capacity. The omission of this maintenance step allowed the rope section within the wedge socket to deteriorate quicker than expected. This resulted in diminished structural integrity and contributed directly to the failure.

IN CONCLUSION:

In conclusion, the investigation determined that the primary cause of the wire rope failure was the presence of internal corrosion at the socket connection, and personnel not following proper maintenance procedures for wire ropes operating in a salt water environment. Wire rope terminations exposed to salt water intrusion are required to be periodically cut back and inspected. However, this "cut and slip" process was not performed, which allowed deterioration of the wire rope to go undetected for longer than it should have. The rope ultimately failed at a location consistent with corrosion weakened strands inside the socket.

Additionally, factors affecting the condition and loading of the fast line A2B system contributed to the incident. The A2B cable pulley at the boom point was found wedged in a manner that caused continuous chafing of the wire rope, resulting in damage that should have been detected during routine crane inspections. This progressive abrasion,

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whether initiated in the storage cradle or during crane operation, resulted in repeated mechanical wear with each boom movement, further diminishing the integrity of the wire rope.

The configuration of the end socket connection also influenced the severity of the failure. When the A2B weight fell, the initial point of impact was the wire rope entering the wedge socket, transmitting enough force to sever the wire rope internally. As the connection design did not provide any opportunity to slow the fall of the weight before contacting the wedge, the full momentum of the falling weight was absorbed at the rope termination. The combination of corrosion, mechanical chafing, and impact loading ultimately caused the parting of the fast line wire rope.

EBI has reinforced its crane inspection requirements by mandating strict adherence to the cut and slip procedure for all wire rope terminations. Additionally, EBI and customer contract personnel have been re-educated on the mandatory cut, slip, and inspect policy governing wire ropes used on EBI cranes. Crane operators have also been directed to comply with mandatory pre use crane inspections to ensure operational readiness and regulatory conformity. As a preventive measure, a secondary lanyard has been installed on all fast line weights so that, in the event of inadequate maintenance or a compromised A2B cable, the auxiliary lanyard will prevent the unintended release or drop of the A2B weight.

18. LIST THE PROBABLE CAUSE(S) OF ACCIDENT:

Equipment failure: Inadequate preventive maintenance- Fast line hoist wire rope dead end termination in wedge socket was never “cut and slipped” per EBI policy. Failure to replace the wire rope in the wedge socket caused the wire rope to become corroded and weakened at the point of impact from the A2B weight.

Equipment failure: Inadequate equipment inspection- Failure to identify the A2B weight cable pulley bolt being bent during inspections prior to the incident. Due to the bent bolt, the pulley was wedged sideways forcing a chaffing of the wire rope which ultimately caused the wire rope to separate and the A2B weight to fall.

19. LIST THE CONTRIBUTING CAUSE(S) OF ACCIDENT:

Human error: Not following company policies/procedures- Crane mechanic/inspector failed to cut and slip the fast line hoist wire rope dead end termination in wedge socket. This allowed weakened and corroded cables to remain in wedge socket during operations.

Work environment: Other weather influences- The saltwater and corrosive environment caused excessive corrosion on the fast line hoist wire rope termination.

20. LIST THE ADDITIONAL INFORMATION:

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21. PROPERTY DAMAGED:

A2B block weight wire rope, A2B weight wire rope pulley, fast line wire rope, wedge socket

NATURE OF DAMAGE:

Broken, bent, separated

ESTIMATED AMOUNT (TOTAL): **$3,153**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

BSEE New Orleans District recommends the Office of Incident Investigations should consider issuing a Safety Alert regarding the incident.

The Safety Alert should focus on performing a more in-depth crane pre-use and following company policy. In this case, the Crane Inspector/Mechanic did not cut and slip a new wedge socket termination as per company policy. The crane pre-use performed did not identify the bent pulley bolt which contributed to the weight becoming detached and falling. The crane pre-use also failed to identify the corrosion on the wire rope at the wedge socket.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: **NO**

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

25. DATE OF ONSITE INVESTIGATION:

14-APR-2026

26. Investigation Team Members/Panel Members:

27. OPERATOR REPORT ON FILE:

28. ACCIDENT CLASSIFICATION:

29. ACCIDENT INVESTIGATION PANEL FORMED: **NO**

OCS REPORT:

30. DISTRICT SUPERVISOR:

Michael J. Saucier

APPROVED DATE: **26-MAY-2026**